T15 Plan

Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://www.fhcp.com/documents/coc/2026-large-group.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-615-4022 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $5,000 Individual/ $10,000 Family Out-of-network providers: Not covered	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, and services not subject to the deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $6,600 Individual/ $13,200 Family Out-of-network providers: Not covered	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.fhcp.com/find-providers/physician or call 1-877-615-4022 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary Care visit to treat an injury or illness	$40 Copay/Visit	Not covered	Additional cost sharing may apply for Allergy shots, Injections and Infusions. See schedule of benefits for telehealth benefit specific cost sharing through designated provider.
	Specialist visit	$80 Copay/Visit	Not covered	Additional cost sharing may apply for Allergy shots, Injections and Infusions.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for laboratory & professional services at an independent clinical lab. Deductible + 30% Coinsurance for x-ray & diagnostic imaging at an independent diagnostic testing center. Deductible + 30% Coinsurance for laboratory & professional services and Deductible + 30% Coinsurance for x-ray & diagnostic imaging at an outpatient hospital facility	Not covered	Prior authorization is required. Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost share. Failure to obtain Prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	$200 Copay at an independent facility / Deductible + 30% Coinsurance at an outpatient hospital facility	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://fm.formularynavigator.com/FBO/126/2026_NGF_Formulary.pdf	Generic drugs – preferred / non-preferred	Retail: $3 Copay per prescription for Preferred at FHCP / Mail Order: $6 Copay per prescription for Preferred / Retail: $10 Copay per prescription for Non-Preferred at FHCP / Mail Order: $27 Copay per prescription for Non-Preferred / Retail: $15 Copay per prescription at select Non-Preferred Retail Pharmacies.	Not covered	31 Days per Benefit Period. Available at Preferred-FHCP and select Non-Preferred Retail Pharmacies Only. Up to 93-day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Non-Preferred Pharmacies.
	Preferred brand drugs	Retail: $30 Copay per prescription at FHCP / Mail Order: $87 Copay per prescription / Retail: $35 Copay per prescription at select Non-Preferred Retail Pharmacies.	Not covered	
	Non-preferred brand drugs	Retail: $55 Copay per prescription at FHCP / Mail Order: $162 Copay per prescription/ Retail: $60 Copay per prescription at select Non-Preferred Retail Pharmacies.	Not covered	
	Specialty drugs – preferred / non-preferred	Retail: 15% Coinsurance for Preferred Specialty drugs at FHCP. 25% Coinsurance for Non-Preferred Specialty drugs at FHCP.	Not covered	31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Not covered	Pre-certification/Pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not covered	Prior approval required. Your benefits / services may be denied.
If you need immediate medical attention	Emergency room care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Waived if admitted.
	Emergency medical transportation	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	None
	Urgent care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Not covered	Pre-certification/Pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$80 Copay/Visit	Not covered	The cost share displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost share.
	Inpatient services	Deductible + 30% Coinsurance	Not covered	Pre-certification/Pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you are pregnant	Office visits	$80 Copay/Visit	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Not covered	Pre-certification/Pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not covered	Pre-certification/Pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.
If you need help	Home health care	Deductible + 30% Coinsurance	Not covered	Prior approval required. Your benefits /

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
recovering or have other special health needs				services may be denied. Coverage limited to 60 days.
	Rehabilitation services	Deductible + 30% Coinsurance	Not covered	Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Deductible + 30% Coinsurance	Not covered	Pre-certification/Pre-authorization of coverage required. Your benefits / services may be denied. Coverage limited to 20 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.
	Hospice services	Deductible + 30% Coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion with the Exception of Limited Services
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-615-4022.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-615-4022.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-615-4022.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayment	$90
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,250**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Primary Care physician office visits (*including disease education)*
Diagnostic test *(blood work)*
Prescription Drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayment	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayment	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.